IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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CERTIFIED MAIL: 7007 3020 0001 4044 7274

April 23, 2013

Collin "Serge" Newberry, Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

Provider #: 135098

Dear Mr. Newberry:

On **April 12, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Life Care Center of Valley View by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance**. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 6, 2013**. Failure to submit an acceptable PoC by **May 6, 2013**, may result in the imposition of civil monetary penalties by **May 28, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

    a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.

    b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

    c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **May 17, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 17, 2013**. A change in the seriousness of the deficiencies on **May 17, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 17, 2013** includes the following:

Denial of payment for new admissions effective **July 12, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 12, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 12, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **May 6, 2013**. If your request for informal dispute resolution is received after **May 6, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF VALLEY VIEW	1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Coordinator Linda Kelly, RN Arnold Rosling, RN, QMRP Amy Jensen, RN Lorraine Hutton, RN, QMRP Survey Definitions: ADL = Activities of Daily Living ADON = Assistant Director of Nursing AIT = Administrator in training BIMS = Brief Interview for Mental Status BMFR= Behavioral/Intervention Monthy Flow Record COPD= Chronic Obstructive Pulmonary Disease CNA = Certified Nurse Aide DC= Discontinue DON = Director of Nursing LN = Licensed Nurse MG = Milligram MAR = Medication Administration Record MDS = Minimum Data Set assessment POA= Power of Attorney PRN= As needed RN = Registered Nurse SS= Social Services TAR = Treatment Record UM= Unit Manager LMSW= Licensed Masters Social Worker	F 000	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. RECEIVED MAY 24 2013 FACILITY STANDARDS	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Collin Sue Mawberry | Executive Director | 5/24/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on the group interview with surveyors, it was determined the facility failed to ensure residents' were afforded privacy during care and treatments. This was true for 1 of 15 sample residents (#12) when blood glucose (BG) checks were done and subcutaneous (SQ) injections were administered to the resident in public areas	F 164	**Corrective Action for Specific Residents and other Residents** Residents #12 Blood Glucose Checks (BGC) and insulin are being administered in a private area. **Other Residents Affected** Any resident with BGC's or insulin injections may be affected by this practice. **What measures will be put into place/systemic changes to prevent recurrence** In-service nursing staff to ensure all residents get their BGC's and insulin injections in a private setting. **Monitoring to ensure deficiency does not recur** Nurse managers will ensure compliance by monitoring that BGC's and insulin injections are done in a private setting. Audit BGC's and Insulin injections: Observe Licensed Nurses (LN) BGC's and insulin injections are performed in private settings. • 2x weekly q8 weeks; • Then 1x month x2 months. DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13

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F 164	Continued From page 2	F 164		

of the facility. The failed practice created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy. Findings included:

Resident #12 was admitted to the facility on 4/8/11 with several diagnoses, including diabetes mellitus (DM).

The resident's recapitulation of Physician Orders for March and April 2013 included orders for BG checks twice daily and Novolog insulin by SQ injection twice daily, both for DM. The BG check order was dated 6/19/12 and the Novolog insulin order was dated 5/16/12.

The resident's Diabetic Administration Records (DAR) for March and April 2013 also included the aforementioned BG checks and insulin orders. The DAR documented BG checks were done and the insulin was administered twice daily during March and in April from 4/1 through 4/12 at 7:30 a.m.

A Group Interview with 7 residents and 2 surveyors was conducted on April 9, 2013 from 10:45 a.m. to 11:30 a.m. When asked about privacy during care and treatments, 1 of 7 residents reported that Resident #12's BG checks were done and injections administered "sometimes" when Resident #12 was by the Nurses' Station. The resident stated, "Sometimes [Resident #12] gets her glucose checked by the Nurses' Station and she gets her insulin right there too. But a nurse supervises that."

On 4/11/13 at 3:30 p.m., the Administrator and DNS were informed of the issue. However, the

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F 164	Continued From page 3 facility did not provide any other information or documentation that resolved the issue.	F 164	F250 **Corrective Action for Specific Residents and other Residents** Resident #5 is being provided behavioral and medically related social services to meet resident's needs. Resident #9 care plan has been updated to include specific non-pharmacological interventions and individualized to include specific behaviors.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure behavioral or medically-related social services were provided to meet residents' individual needs for 2 of 11 sampled residents (#5 and #9). This failed practice had the potential to cause avoidable decline in physical, mental and psychosocial well-being. Findings include: 1. Resident #5 was admitted to the facility on 11/01/11, with multiple diagnoses (dx) including: dementia, anxiety disorder, and depression. Resident #5's 10/30/12 significant change MDS, coded moderately impaired cognitive skills, inattention continuously present and did not fluctuate, easily distracted, out of touch, and difficulty following what was said. Additionally, the MDS coded 2-6 days of trouble falling or staying asleep, or sleeping too much during the previous two weeks. Resident #5's Mood Care Plan, dated 10/30/12, included the following problem: potential for	F 250	**Other Residents Affected** Other residents with behaviors will be provided behavioral and medically related social services and non pharmacological interventions specific to their needs. **What measures will be put into place/systemic changes to prevent recurrence** In-service social services to be actively involved with residents with behaviors and document appropriate interactions to develop a behavior care plan with individualized specific behavior interventions as needed and communicate with families and identify supportive services as indicated. Licensed social worker also in-serviced on effective communication with C.N.A.'s to ensure appropriate non-pharmacological interventions are put in place. In-service staff to document any new behaviors on the 24-hour report.	

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F 250	Continued From page 4 alteration in mood; dx of depression and dementia. The following approaches were documented for depression and dementia: Anti-depressant per MD order, monitor for effectiveness, notify MD of apparent changes, IDT (Interdisciplinary Team) to review quarterly and PRN (as needed), offer empathy during encounters and validate her feeling as she expresses them. NOTE: Review of the Care Plan, dated 10/30/12, documented a hand written DC (discontinue) for the anti-depressant, but did not document a date for the DC. An additional hand written note documented anti-depressant restarted on 3/20/13. Resident #5's Mood Care Plan, dated 1/07/13, included the following problem: "Res [ident] [with] agitation yells out constantly." Her Mood Care Plan was not revised until 2/06/13, revisions included the following approaches: Sleep monitor, music therapy, remove from stimuli environment, rest periods [between] meals prn, eat out at nurses station p.m. Resident #5's Mood Care Plan, dated 3/07/13, included the following problem: [increased] agitation calls out continuously. POA refuses [treatment with] pharmacological approach. Resident #5's BMFR (Behavior Monthly Flow Record), dated March 2013 identified the following behaviors: (1) signs and symptoms of anxiety: calling out repetitively and (2) signs and symptoms of anxiety: restlessness, agitation or anxious concerns	F 250	**Monitoring to ensure deficiency does not recur** Audits will be completed by Director of Nursing at behavior meeting ensuring resident's behavior needs are being met and social services involvement is occurring and care plan updated if indicated. • 1x weekly q8 weeks • 1x monthly q2 months Audit: Unit Managers or SDC will conduct C.N.A. Staff interviews to ensure staff are aware of non-pharmacological interventions. • 2x/week q8 weeks • 1x month q2 months ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13 Audits to begin 5/17/13

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F 250	Continued From page 5 The resident's BMFR, required each shift document the number of behavioral episodes, interventions, outcomes, and side effects that occurred on their shift. The BMFR documented behaviors were continuously observed by one or more shifts every day for the month of March 2013. Resident #5's SS (Social Service) notes documented the following: *11/01/12, documented, "LMSW met briefly with resident... she was very anxious and rambling non-sensically." * 11/05/12, documented, "Resident is calling out and anxious, stating, 'she does not feel good.' She is unable to tell me what is wrong just that 'she does not feel good.' She is perseverating on everyone who walks by her door and calling out for them to come talk to her." *11/11/12, documented, "...Resident is alert with confusion. She is calm and pleasant at the moment of interview however reports from nursing staff that she continues to have behaviors of calling out." * 03/21/13, documented, "...Resident #5 is continually calling out and has begun to get aggressive and abusive with staff." NOTE: SS notes dated 11/01/12 through 3/21/13, did not document SS was actively involved in Resident #5's care, to include development of a behavior plan, communication with family, and identifying support services to address Resident's individual needs. On 4/11/13 at 10 a.m. the DON was interviewed about SS involvement with Resident #5's family members and behavioral plan. She stated	F 250		

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F 250	Continued From page 6 "Second Floor Unit Manager has been involved with POA. SS has not been involved with POA specifically as the POA has had a good rapport with UM #2." 4/11/13 at 1:55 p.m. SS and DON were interviewed and asked the following questions: *How does the facility implement SS interventions to assist the resident in meeting treatment goals and has SS established and maintained a relationship with resident's family or legal representative? SS stated,"With Resident #5 it is difficult. After I met with the Ombudsman regarding POA's refusals to allow any medications to relieve her distress and agitation the POA would no longer speak to me." *How does SS monitor Resident's progress in improving physical, mental, and psychological functioning? SS stated, "Behavior meeting once a week, alert charting, and dementia training for staff monthly and annually." *How does the Care Plan link goals to psychological functioning and resident's well-being? SS stated,"The individual's Care Plan needs to be specific to her needs. We will work towards that as it is vague." *What has SS done to address resident's behavioral symptoms? SS stated they discuss Resident #5 in their weekly behavior meetings or she contacts the Ombudsman. She also stated that she has not been involved in developing a Behavioral Care Plan or a treatment plan to assist with Resident #5's individual needs. 04/11/13 at 3:30 p.m. the Administrator was notified. No additional information was provided.	F 250		

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F 250	Continued From page 7	F 250		

2. Resident #9 was admitted to the facility on 10/29/07 with diagnoses that included vertigo, abdominal pain, obsessive compulsive disorder, macular degeneration, and retention of urine. Resident #9's primary source of nutrition was received through tube a feeding.

Resident #9's most recent quarterly MDS assessment documented she required physical assistance for personal hygiene and toileting. Resident #9 was assessed to be cognitively intact.

The resident's 4/13 Physician Orders (recapitulation) included an order for Zyprexa 5 mg at bedtime for obsessive-compulsive disorder.

Resident #9's Psychosocial Care Plan (CP), dated 10/2/09, included in the "Goals" section "Mood and behavior indicators will be minimize (sic) over the next 90 days." The "Approach" section documented the use of medication, to notify the physician of apparent changes in mood and to monitor behaviors. The "Anxiety" section of the CP, dated 10/2/10, identified anxiety and chronic obsession related to bowels and gas fixation. The approach section included medication as ordered and to monitor the hours of sleep. The approach sections did not identify nonpharmalogical interventions to address the behaviors.

The Behavior/Intervention Monthly Flow Record (BIMFR) included in the behavior section "delusional thoughts continually focusing on bodily functions." The form included standard

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F 250	Continued From page 8 intervention codes such as redirection, 1 on 1, toilet, give food or fluids etc. The interventions did not include specific interventions for Resident #9. When asked, on 4/11/13 at 1:25 p.m., what behaviors were displayed and how they were addressed LN #8 stated Resident #9 focused on body functions and the nurse would record the behavior. At 1:30 p.m. on 4/11/13, CNA #6 stated the resident focused on body functions. CNA stated the behavior was addressed by telling the nurse. At approximately 1:40 p.m., CNA #7 stated the resident was obsessive about bodily functions. CNA #7 stated the information would be reported to the nurse and then the CNA would go back and tell the resident what the nurse said. The CNA clarified the resident was told the nurse would bring a pain pill or the resident's feeding tube was just checked. On 4/11/13 at 3:30 p.m., the Administrator, DON, ADON, Nurse Consultant, and AIT were informed that the CNA's interviewed did not identify the interventions listed on the BIMFR. The facility provided no further information.	F 250		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		

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F 280	Continued From page 9 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and observation, the facility failed to ensure that care plans were revised to address residents' current status and issues. This was true for 4 of 16 sampled residents (#s 2, 5, 7, & 16). The lack of revised care plans had the potential to affect care provided to the residents because care plans did not give current/accurate instructions and/or interventions for staff to follow to meet identified needs. Findings include: 1. Resident #16 was admitted to the facility on 3/16/12, with diagnoses including Alzheimer's Disease, hypothyroidism, depression, anemia, atrial fibrillation, and restless legs syndrome. The resident's quarterly MDS assessment, dated 6/21/12, coded the resident was at risk for skin breakdown. Resident #16's Care Plan, generated on 6/21/12,	F 280	F280 **Corrective Action for Specific Residents and other Residents** Resident #16 is discharged. Resident #2 current physician ordered diet is on care plan and behavior of throwing food on the floor is care planned. Resident #4 Merri Walker has been dc'd from care plan. Resident #7 Care plan has been updated to have current physician ordered diet and thin liquids. AFO has been removed from care plan. **Other Residents Affected** Other residents could be affected by this practice. Residents will have their care plans updated to reflect: Changes in skin integrity along with treatments provided, changes in diet or liquid consistency will be updated, throwing food on floor, dc AFO, and dc of Merri Walker. **What measures will be put into place/systemic changes to prevent recurrence** In-service IDT and LN and MDS nurses on ensuring accuracy of care plans. In-service staff to report and write on 24 hour report regarding residents who throw food on the floor or other socially inappropriate behaviors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 10 documented a problem of "Potential for impairment of skin integrity [related to] incontinence, requires assistance with mobility." The problem onset date was 3/16/12 and the interventions included: * "Weekly skin assessment" * "Assist to toilet every 2 hours and prn [as needed]. One assist with toileting needs." * "Perineal care after each incontinence and apply barrier cream The resident's Weekly Skin Integrity Data Collection form documented redness of the buttocks and/or perineal areas on 5/23/12, 6/20/12, 6/27/12, 7/10/12, 7/17/12, 7/24/12, 7/31/12, and 8/7/12. A FAX sent by the facility to the resident's physician, dated 6/13/12, documented, "Increased redness and some blistering to periarea and inner thighs." A second FAX sent to the resident's physician on 6/18/12, also reported a, "very red peri area." The resident's physician's orders, dated 6/18/12 through 8/6/12, documented treatment orders for the resident's redness and excoriation in the periarea and perianal/buttocks area which worsened after the resident developed a C-Diff infection with diarrhea: * 6/18/12 - "Nystatin Powder to affected areas [every] shift then prn [as needed] when healed." * 7/20/12 - "Culture for C-Diff" * 7/23/12 - "Flagyl 500 [milligrams] BID [Twice per day] for 7 days... Isolation precautions per facility protocol." * 8/4/12 - "Vancomycin (oral) 1 [gram] daily [for] 7 days. Keep perineal and perianal areas clean...	F 280	**Monitoring to ensure deficiency does not recur** Audit: Unit Managers to audit care plans for accuracy and/or need for revision based on copies of new orders and documentation on the 24hour report on new and current resident behaviors. The audit will include throwing food on floor, or other anti-social behaviors, diet changes, merri-walkers, AFO, new orders for treatment of changes in skin integrity. Unit managers to ensure care plans are updated or revised or new care plan created based on audits. • 5x/week q2months • 2x/week q2 months Audit: Behavior Management Team to audit behavior care plans of 10 random residents with behavior monitors to ensure accuracy and that specific, individualized interventions are in place: • monthly q4 months ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Complianee: 5/17/2013**	Audits to begin 5/17/13 Audits to begin 5/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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F 280	Continued From page 11	F 280		

and open to air as much as possible." Note: related physician's progress notes dated 8/4/12, documented, "... accompanied by daughter who is significantly concerned re: perineal [and] perirectal area. [Resident] has had recurrent diarrhea [and] C-diff."
* 8/4/12 - "Cleanse peri-area [and] ... [with] soap and water BID until clear."
* 8/6/12 - "Calmoseptine to buttocks/periarea after each incontinent episode."
* 8/6/12 - "Apply ultra dry cloth in folds, change twice daily and prn."
* 8/10/12 - "Lidocaine cream 4% mix with aquaphor to rectal area with each incontinent episode..."

The resident's 6/21/12 Care Plan was never revised to address the perineal and perirectal skin issues the resident experienced between 6/13/12 and her discharge from the facility on 8/10/13. The Care Plan was not updated to reflect:
* The need to assess, document, and monitor the condition (6/13/12).
* To use the Nystatin Powder on the affected areas [every] shift then (6/18/12) prn.
* Keep the perineal and perianal area clean... and open to air as much as possible (8/4/12).
* Cleanse peri-area [and] ... [with] soap and water BID until clear (8/4/12).
* Calmoseptine to buttocks/periarea after each incontinent episode (8/6/12).
* Apply ultra dry cloth in folds, change twice daily and prn (8/6/12)

On 4/11/12 at 8:50 am, the DON was interviewed regarding Resident #16's skin condition in June 2012 through August 2012. During the interview, the DON was asked about the lack of care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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F 280	Continued From page 12	F 280		

planning. The DON stated she would review the chart and provide any additional documentation or information she found. The DON/facility was unable to provide additional documentation or information that resolved the concerns.

2. Resident #2 was admitted to the facility, on 7/9/07, with diagnoses of late effect cerebrovascular dysphasia, diabetes mellitus type II, dementia with behavior disturbance, psychosis and depressive disorder.

The most recent quarterly MDS, dated 12/4/12, documented the resident:
* had short term memory problems,
* had severely impaired decision making skills,
* required extensive assistance of one to two staff for transfers, dressing, toilet use, personal hygiene and bathing.
* was always incontinent of urine.

The resident was observed on 4/9/13 to only get a liquid and dessert delivered to him for dinner. The RD was asked 4/10/13 at 10 a.m. why the resident did not receive "Finger foods" as identified in the 2/27/12 nutrition care plan. The RD stated that the resident only received what he asks for because if he received anything else he threw his tray on the floor. The RD indicated that the care plan should have the finger food removed and the behavior of throwing food on the floor added to the care plan. No further information was provided.

3. Resident #4 was admitted to the facility on 10/12/12 with diagnoses of intracranial hemorrhage, altered mental status, dementia and depressive disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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LIFE CARE CENTER OF VALLEY VIEW	1130 NORTH ALLUMBAUGH STREET BOISE, ID. 83704

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F 280	Continued From page 13	F 280		

The most recent quarterly MDS, dated 1/15/13, documented the resident:
* had short and long term memory problems,
* was severely impaired in decision making skills,
* required extensive assistance of one to two staff for transfers, dressing, toileting, personal hygiene and bathing.

The resident's care plan had a problem added on 1/22/13 that documented, "At times will not allow staff to take out of merry walker for meals and q2hrs [every 2 hours] when agitated." The care plan was not changed when the merry walker was discontinued.

The DON and consultant were interviewed on 4/11/13 at 10:00 a.m. and indicated the merry walker had been discontinued and the care plan should have been revised.

4. Resident #7 was admitted to the facility on 10/19/09 with diagnoses which included CVA (cerebrovascular accident), hypertension, UTI (urinary infection) and sepsis.

a. Resident #7's, 2/11/13 MDS assessment documented moderate cognitive impairment and the resident required supervision and setup help only for eating.

Attached to Resident #7's Care Plan was a "Feeding Guidelines for (Resident Name)". The Feeding Guidelines (FG) documented the resident was to eat and drink separately and was to have nectar thick liquids.

During the breakfast observation, on 4/9/13 at 8:45 a.m. Resident #7 was observed to have thin liquids and to be eating without supervision. The Activities Director (AD) was assisting residents by bringing their breakfast trays to the table. The AD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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LIFE CARE CENTER OF VALLEY VIEW	1130 NORTH ALLUMBAUGH STREET BOISE, ID. 83704

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F 280	Continued From page 14 stated Resident #7 no longer required thickened liquids or close supervision while eating. On 4/10/13 at 9:00 a.m. the RD stated the FG document should have been "pulled" from the Care Plan. b. The resident's 10/29/09 Care Plan for Self Deficit Care included the resident was to wear a right ankle foot orthotic (AFO) when he was out of bed. On 4/8/13 at 12:46 p.m., after lunch, CNAs #11 and #12 were observed transferring Resident #7 from his wheelchair to his bed. The resident did not have an AFO on. On 4/11/12 at 9:20 a.m. the DON stated the AFO had been discontinued because the resident refused to wear it. The care plan had not been updated.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure staff adhered to professional standards of care. This was true for 2 of 11 sample residents (#s 1 and 10) and 1 of 1 random residents (#19) when: a) The central, or middle, of Resident #1's fingertip was stuck to obtain a blood drop for a blood glucose (BG) check. The failed practice created the potential for the resident to experience increased discomfort. b) Resident #10's lung sounds, pulse, and pulse	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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F 281	Continued From page 15 oximetry level were not assessed before administration of a PRN (as needed) nebulizer breathing treatment. Also, the resident's lung sounds were not assessed after the treatment. Without a complete assessment (lung sound assessments before and after the nebulizer treatment and pulse and pulse oximetery monitoring prior to the treatment) the efficacy of the DuoNeb nebulizer was not monitored and placed the resident at risk for an unnecessary medication. c) Resident #19's proton pump inhibitor (PPI) medication was administered right after breakfast rather than before the meal. This failure created the potential for the resident to experience less than optimal control of gastric acidity. Findings included: 1. Note: Clinical Nursing Skills, 7th edition, 2010, by Perry and Potter, pages 1155 and 1156, state, "... 9 Choose puncture site. Puncture site should be vascular. In adult, select lateral side of finger; be sure to avoid central tip of finger, which has more dense nerve supply. ..." Note: Lippincott Manual of Nursing Practice, ninth edition, 2010, by Lippincott, Williams and Wilkins, page 947, state, "Blood Glucose Monitoring Technique... Nursing Action...Prick the patient's finger lateral to the fingertip using lancet/lancing device... [Rationale] This avoids the most sensitive area of the fingertip..." On 4/9/13 at 4:25 p.m., during a BG check observation, LN #4 stuck the lancing device in the middle (or ball) of the tip of Resident #1's left middle finger to obtain blood for the test.	F 281	F281 **Corrective Action for Specific Residents and other Residents** Resident #1 professional standards of practice is being met by checking BG on lateral side of finger. Resident #10 lung sounds, pulse, pulse oximetry are being checked before prn nebulizer treatments are given and lung sounds are being checked after prn nebulizer treatments. Resident #19: PPI given prior to breakfast on empty stomach at 7am. **Other Residents Affected** Other residents who get BGC's, nebulizers or PPI's could be affected and will have their BGC taken on lateral aspect of finger. Lung sounds, pulse, pulse oximetry will be checked prior to prn nebulizer treatment and lung sounds after prn nebulizer treatment. Other Resident's who take PPI will be given prior to breakfast, on an empty stomach at 7am. **What measures will be put into place/systemic changes to prevent recurrence** In-service: Nursing staff to ensure PPI's are given prior to breakfast, on an empty stomach, at 7:00am. BGC's are done on lateral aspect of finger and lung sounds, pulse and pulse oximetry are done prior to [nebulizer treatment and lung sounds after nebulizer treatment.	

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F 281	Continued From page 16 Immediately afterward, when asked about the location of the fingerstick, LN #4 pointed to the ball of the resident's left middle fingertip and confirmed she had done the fingerstick there. When informed the central tip of the fingers are more sensitive than the lateral aspect and fingersticks to the ball of the fingertip may cause increased discomfort for the resident, the LN expressed appreciation. On 4/11/13 at 3:30 p.m., the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility. 2. Note: Perry and Potter, Clinical nursing skills & techniques, 2010, 7th edition, page 562 states, "Patients who receive drugs by inhalation frequently suffer from chronic lung disease. Drugs administered by inhalation provide control of airway hyperactivity or constriction..." Step 4 of Administering Nebulized Medications states, "Assess pulse, respirations, breath sounds, pulse oximetry, and peak flow measurement (if ordered) before beginning treatment." The rationale states, "Establishes a baseline for comparison during and after treatment." Note: Lippincott Manual of Nursing Practice, ninth edition, 2010, by Lippincott, Williams and Wilkins, page 240, state, "Administering Nebulizer Therapy... Procedure...Nursing Action 1. Auscultate breath sounds, monitor the heart rate before and after the treatment for patients using bronchodilator drugs. Rationale 1. Bronchodilators may cause tachycardia [fast heart rate], palpitations, dizziness, nausea, or nervousness."	F 281	**Monitoring to ensure deficiency does not recur** Nurse managers to do med pass audits to ensure PPI's are given prior to breakfast, on an empty stomach, at 7:00am: • 2x weekly q8 weeks • 1x monthly q2 months Nurse manager to do med pass audit to ensure BGC's are done on lateral aspect of finger and lung sounds, pulse, pulse oximetry prior to prn nebulizer treatment and lung sounds after prn nebulizer treatment. • 2x weekly q8 weeks • 1x monthly q2 months ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13 Audits to begin 5/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 17	F 281		

Resident #10 was admitted to the facility on 1/30/13 with multiple diagnoses which included quadriplegia, tracheostomy, unspecified late effects of cerebrovascular disease, and dysphagia (difficulty swallowing).

A recapitulation of the resident's Physician Orders for April 2013 included a 1/30/13 order for "Duoneb [sic] treatment inhaled every 4 hours PRN" for acute respiratory failure.

Resident #10's Care Plan identified the problem, "[Low] oxygen saturation at times post [after] trach removal" on 4/8/13. Interventions included, "O2 [oxygen] 0-2 liters [per minute] to maintain Sats [saturation levels] 90%. Encourage cough, deep breathing. Monitor lung sounds. Monitor O2 Sats each shift, PRN." The care plan did not include anything about nebulizer treatments.

On 4/8/13 at 2:20 p.m., during a medication pass observation, LN #2 did not auscultate Resident #10's lung sounds or check the resident's pulse or pulse oximetry level before she administered a PRN DuoNeb (a combination of 2 bronchodilator medications, albuterol and ipratropruim) breathing treatment to the resident. After the nebulizer treatment, the LN did monitor the resident's pulse oximetry and heart rate; however, again she did not ausculate the resident's lung sounds.

On 4/11/13 at 3:30 p.m., the Administrator and DNS were informed of the observation and concern. However, no other information or documentation was received from the facility.

3. During a medication pass observation on

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	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF VALLEY VIEW	1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704

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F 281	Continued From page 18 4/8/13 at 9:00 am, LN #4 administered omeprazole by mouth to Resident #19. LN #4 stated the resident had finished her breakfast meal around 8:30 am. Federal guidelines issued through letter S&C:13-02-NH on November 2, 2012 documented, "PPIs [Proton Pump Inhibitors] such as lansoprazole (Prevacid) and omeprazole (Prilosec), are routinely used in nursing homes settings. For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30 - 60 minutes before eating. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system before food activates the acid pump so that the peak concentration of PPI will coincide with maximal acid secretion... " The Nursing 2013 Drug Handbook (NDH 2013), page 1011, under the drug omeprazole, documented, "Give drug at least 1 hour before meals." The NDH 2013 documented the onset time for the drug to start working was 1 hour, the peak time 30 minutes to 2 hours, and half-life was 30 - 60 minutes. Resident #19's April 2013 Physician Orders (Recapitulation) listed, "Omeprazole 20 mg po daily for esophageal reflux." The April 2013 Physician's Orders listed 7:00 as the administration time. In addition, the April 2013 MAR also listed the administration time as 7:00 am. LN #4 was interviewed immediately after she administered the omeprazole and asked about the 9:00 am administration time. The LN stated	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 19 that they had spoken with the Pharmacist who said that a later administration time would not affect the effectiveness of the medication. LN #4 later, on 4/10/13 at 10:00 am, recanted her statement saying that she might have misunderstood the pharmacist, "He may have been talking about another drug." On 4/11/13 at 8:50 am, the DON was interviewed about the administration time and asked to provide a copy of their policy for administering PPIs and other medications that had specific recommendations for administration in regards to food. The DON later provided a list of medications, from a policy/procedure (P/P) dated 2008, that was titled "Drug Administration Recommendations Regarding Meals." The P/P listed 41 medications including omeprazole. The recommendations for omeprazole documented, "Before meals; best if taken before breakfast."	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview and observation, it was determined the facility failed to ensure that physician's orders and resident care plans were consistently followed.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF VALLEY VIEW	1130 NORTH ALLUMBAUGH STREET BOISE, ID 83704

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F 309	Continued From page 20 This was true for 5 of 16 sampled residents reviewed (#s 1, 5, 6, 11 & 16) and had the potential to affect residents' health status in the areas of skin integrity, and upper body strength and interfere with their optimal possible improvement. Findings include: 1. Resident #16 was admitted to the facility on 3/16/12, with diagnoses including Alzheimer's Disease, hypothyroidism, depression, anemia, atrial fibrillation, and restless leg syndrome. The resident's quarterly MDS assessment, dated 6/21/12, coded the resident was at risk for skin breakdown. Resident #16's Care Plan, generated on 6/21/12, documented a generic problem of "Potential for impairment of skin integrity... related to incontinence, [and] requires assistance with mobility." The problem onset date was 3/16/12 and the interventions included: * "Weekly skin assessment" * "Assist to toilet every 2 hours and prn [as needed]. One assist with toileting needs." * "Perineal care after each incontinence and apply barrier cream. Note: The resident's 6/21/12 "Potential for Skin breakdown" Care Plan was not revised to reflect changes in the resident's perineal/perirectal skin condition and needed/recommended interventions, between 6/21/12 and the resident's discharge on 8/10/12. Please refer to F 280 for details. The resident's Weekly Skin Integrity Data Collection form documented redness of the	F 309	**Corrective Action for Specific Residents and other Residents** Resident #16 has been discharged. Resident #11 physician's orders and care plan are being followed on application of hemorrhoid treatment. Resident #6 OT evaluation has been completed. Resident #1 Care plan has been updated due to increased mobility and floating heels has been discontinued. Resident #5 WC arms have been padded. **Other Residents Affected** Other residents with specific physician orders for skin treatments may be affected. New treatment orders will be transcribed on TAR, treatments will be performed as ordered and initialed as completed by LN's. Other residents with OT evaluations will be communicated to OT department as orders received. Residents with care plan interventions of floating heels and padded WC arms could be affected and will have their interventions in place.	

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	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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F 309	Continued From page 21 buttocks and/or perineal areas on 5/23/12, 6/20/12, 6/27/12, 7/10/12, 7/17/12, 7/24/12, 7/31/12, and 8/7/12. A FAX sent by the facility to the resident's physician, dated 6/13/12, documented, "Increased redness and some blistering to periarea and inner thighs." A second FAX sent to the resident's physician on 6/18/12 also reported, "very red peri area." The resident's physician's orders, dated 6/18/12 through 8/6/12, documented treatment orders for the resident's redness and excoriation in the periarea and perianal/buttocks area which worsened after the resident developed a C-Diff infection with diarrhea: * 6/18/12 - "Nystatin Powder to affected areas [every] shift then prn [as needed] when healed." * 7/20/12 - "Culture for C-Diff" * 7/23/12 - "Flagyl 500 [milligrams] BID [Twice per day] for 7 days... Isolation precautions per facility protocol." * 8/4/12 - "Vancomycin (oral) 1 [gram] daily [for] 7 days. Keep perineal and perianal areas clean... and open to air as much as possible." Note: related physician's progress notes dated 8/4/12, documented, "... accompanied by daughter who is significantly concerned re: perineal [and] perirectal area. [Resident] has had recurrent diarrhea [and] C-diff." * 8/4/12 - "Cleanse periarea [and] ... [with] soap and water BID until clear." * 8/6/12 - "Calmoseptine to buttocks/periarea after each incontinent episode." * 8/6/12 - "Apply ultra dry cloth in folds, change twice daily and prn." * 8/10/12 - "Lidocaine cream 4% mix with	F 309	**What measures will be put into place/systemic changes to prevent recurrence** In-service: Nursing staff to ensure new treatment orders are transcribed correctly on TAR, treatments are given as ordered and initialed as completed. Documented interventions of floating heels and padding wheelchair arms on care plan must be implemented. Therapy must be notified if OT orders are received. **Monitoring to ensure deficiency does not recur** Audit: Nurse managers to audit new treatment orders to ensure that new tx orders are transcribed on to TAR correctly. • 1x week q8 weeks • 1x month q2 Audit: Nurse managers to audit TAR for initials attesting that ordered treatments were completed. • 1x week q8 weeks • 1x month q2	Audits to begin 5/17/13 Audits to begin 5/17/13

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F 309	Continued From page 22 aquaphor to rectal area with each incontinent episode..." The Treatment Administration Records (TAR) indicated inconsistent administration of the physician's orders between June 2012 and August 2012. For example: * The June 2012 TAR did not document that the 6/18/12 order for Nystatin Powder on every shift, was administered on 6/29/12 or 6/30/12 evening shifts. * The August 2012 TAR did not document that the resident's perineal and perianal areas were kept open to air, "... as much as possible," on 7/6, 7/7, or 7/10. * The August 2012 MAR also failed to document the resident's peri area was cleansed with soap and water on the day shift of 8/4/12 and the evening shift of 8/8/12. In addition, Nurses Notes, dated 6/21/12 through 8/2/12, did not document the resident's reddened perineal/perirectal area, sores on the peri-area, the resident's response to treatment, or if/when the condition began to worsen. Related to the physician's orders, dated 8/4/12, to keep the perineal and perianal areas clean and open to air and to cleanse the peri-area [with] soap and water BID, the Nurses Notes still failed to document a thorough assessment of the perineal and perirectal area or the resident's response to treatment on 8/4/12, 8/5/12 and 8/6/12. On 8/6/12 at 1:00 pm, a Nurses Note documented, "Resident's daughter had concerns regarding sores on buttocks/periarea. Concerned	F 309	Restorative nurse to audit that care plans are being followed to float heels and padded wc arms are in place: Restorative or designee to audit • 2x/week q8 weeks, • 1x month q2months Unit managers to audit all new orders for OT orders and ensure communication has occurred with OT. • 5x/week x8 weeks ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13 Audits to begin 5/17/13

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F 309	Continued From page 23	F 309		

with mom being open to air [and] ensuring keeping clean [and] dry. Also wants to make sure nursing staff are following the orders. I reassured daughter that I would educate the nurses [and] C.N.A.s on ensuring this gets done daily as ordered [and] daughter happy with plan. Will continue to monitor." Note: Nurses Notes dated 8/7/12 through 8/10/13, following the daughters visit, did document the condition of the peri/rectal area and response to treatment.

On 4/11/13 at 8:50 am, the DON was interviewed regarding Resident #16's skin condition in June 2012 through August 2012. During the interview, the DON was asked about the lack of documentation regarding the resident's skin condition, the lack of care planning, and the inconsistent documentation regarding treatment administration per physician's orders. The DON stated she would review the chart and provide any additional documentation or information she found. The DON/facility did not provide additional documentation or information that resolved the concerns.

2. Resident #11 was admitted to the facility on 9/19/08 and readmitted on 7/7/12. The resident's current diagnoses included multiple sclerosis, osteoporosis, congestive heart failure, obsessive/compulsive disorder, and hemorrhoids.

The resident's 3/14/13 Quarterly MDS Assessment coded a 12 on the BIMs, indicating the resident was cognitively intact, and that the resident received applications of ointments/medication other than to the feet. (Note: The 7/11/12 and 9/23/12 Quarterly Assessments also coded the resident was

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F 309	Continued From page 24 cognitively intact and received applications of ointments/medications other than to the feet.) Resident #11's April 2013 Physician Recapitulation orders instructed nursing staff to apply, "Preparation H ointment PR [per rectum] twice daily for hemorrhoids." The start date for this order was 7/9/12. The resident's Care Plan, dated 3/15/12, documented the problem, "Fixation with bodily functions... perseverates on hemorrhoids." The onset date for this problem was listed as 7/7/12. Interventions included, "Routine hemorrhoid therapy." TARs for August and September 2012, and March and April 2013, documented the resident should receive the Preparation H PR ointment at 10:00 am and 9:00 pm. The ointment was not documented as administered on 3/19/12 and 3/21/12 on am shift, and 3/29/12 on the pm shift. In addition, August 2012 TARs revealed no documentation for the administration of the ointment on 8/10/12 day shift, 8/14, 17, and 31, on the evening shift. September TARS failed to document the medication was administered on 9/23 day shift, and 9/10, 26, and 27 on evening shift. During an interview on 4/8/13 at 1:50 pm Resident #11 was asked if she consistently received her medications and treatments. The resident stated that staff, "Treat me wonderful," and "I can't say enough about them." When asked specifically about her hemorrhoid treatment, the resident stated, "Sometimes I do not get it but they are doing better now."	F 309		

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F 309	Continued From page 25 On 4/10/13 at 9:00 am, the DON was notified of the absence of consistent documentation regarding Resident #11's hemorrhoid treatment. The DON was unable to provide additional information or documentation that resolved the concerns. On 4/12/13 at 11:30 am, the DON and Administrator were notified that a complaint had been filed with the Bureau of Facility Standards that indicated back in August/September 2012, an identified resident did not consistently receive her hemorrhoid treatment and had been upset by it. No additional information or documentation was provided by the facility. 3. Resident #6 was admitted to the facility on 7/4/08 and readmitted on 9/29/11. The resident's current diagnoses included chronic obstructive asthma, chronic airway obstruction, atrial fibrillation, diastolic heart failure, osteoporosis, lumbago and generalized muscle weakness. The resident's 2/13/12 Quarterly MDS Assessment coded a 13 on the BIMs indicating the resident was cognitively intact, and the resident used a wheelchair for mobility. A physician's order, dated 3/8/13, requested an OT (Occupational Therapy) evaluation related to a decrease in BUE (Bilateral Upper Extremities) strength. Related Nursing Notes, dated 3/8/13 at 2:25 pm, documented, "Res[ident] seen by [Nurse Practitioner] for prn [as needed] visit due to	F 309		

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F 309	Continued From page 26 complaints of hand tremors and having increased episodes of glasses of fluids slipping out of her hands and spilling fluids on her. new referral for OT eval[uation] and treat[ment]. Left voicemail for daughter to call for an update." Resident #6's medical records, dated 3/8/13 through 4/9/13, contained no documentation indicating that an OT evaluation was completed in response to the 3/8/13 order. During an interview on 4/10/13 at 9:00 am, the DON was asked about the OT evaluation for Resident #6. The DON stated she would look for the evaluation. On 4/11/13 at 8:50 am, the DON confirmed that the OT evaluation had not been completed. On 4/12/13 at 11:55 am, the DON stated she was still not clear on if there was a communication failure on nursing's part or within the OT department. The DON called on 4/15/13 at 12:30 pm to state that she confirmed nursing staff did not communicate the need for an OT evaluation to the OT department. 4. Resident #1 was admitted to the facility on 10/8/12 with a history of myelodysplastic syndrome (a disease in which the bone marrow does not make enough healthy blood cells). The resident was readmitted on 1/19/13 with multiple diagnoses including systolic heart failure, diabetes mellitus, and debility and weakness. On 2/19/13, hospice services were started for congestive heart failure. Resident #1's significant change MDS assessment, dated 2/21/13 coded, in part: * Cognitively intact with a BIMS score of 14;	F 309		

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F 309	Continued From page 27 * Able to hear, see, and speak without problem; * Able to understand others and to be understood; * Limited one person assistance for bed mobility; * At risk for pressure ulcers; * No unhealed or healed pressure ulcers; and * No venous or arterial ulcers. Resident #1's Care Plan identified the problem, "Potential for impairment of skin integrity r/t [related to] decreased mobility...1/19/13-blister on left heel upon admit from hospital-resolved 2/18/13. Approaches to this problem included, "Float heels when in bed." Resident #1 was observed lying on the bed with both heels in contact with the mattress on 4/8/13 at 3:00 p.m., 4/9/13 at 11:40 a.m. and 2:15 p.m., and 4/11/13 at 1:40 p.m. and 2:30 p.m. During all of the aforementioned observations, only 1 pillow was noted on the resident's bed and it was always under the resident's head. In addition, no other pillows, or heel floating devices were visible in the resident's room. On 4/9/13 at 3:45 p.m., CNA #5 was observed as she transferred Resident #1 from bed to wheelchair then into the restroom. While the CNA waited in the resident's room, she was asked if the resident's heels were supposed to be floated when the resident was in bed. The CNA said the resident would not keep his heels floated and frequently he would "kick the pillow on the floor." She stated, "We've tried." When asked where were the pillow or pillows to float the resident's heels, CNA #5 confirmed there was only 1 pillow for Resident #1. The CNA stated, "I'm not sure if it's being washed or what."	F 309		

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F 309	Continued From page 28 On 4/10/13 at 11:40 a.m., the First Floor Unit Manager (FFUM) was asked if Resident #1's heels were supposed to be floated when the resident was in bed. The FFUM reviewed the resident's care plan then stated, "He's supposed to have his heels floated." On 4/11/13 at 3:30 p.m., the Administrator and DON were informed of the issue. However, no other information or documentation was received from the facility. 5. Resident #5 was admitted to the facility on 11/01/11, with multiple diagnoses including: heart failure, GERD, pneumonia, dementia, depression, anxiety disorder, and COPD. Resident #5's skin care plan, dated 12/22/12, documented an intervention of: "W/C (wheelchair) arms padded. " On 4/10/13 at 1:30 p.m. resident's wheelchair was observed without padding on the arms. On 4/11/13 at 9:30 a.m. resident's wheelchair was observed without padding on the arms. On 4/11/13 at 4:30 p.m. the Administrator and DON were notified. No additional information was provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on a complaint received by the BFS on 10/30/12, staff interview, resident interview and record review, it was determined the facility did not ensure residents received necessary care and services to maintain good personal hygiene for 2 of 11 residents (#s 7 and 9) sampled for assistance with ADLs. This deficient practice had the potential to cause dental health decline when residents did not receive the necessary amount of assistance with oral hygiene. Findings include: 1. Resident #9 was admitted to the facility on 10/29/07 with diagnoses which included vertigo, abdominal pain, obsessive compulsive disorder, macular degeneration, and retention of urine. Resident #9's primary source of nutrition was received through tube feeding. Resident #9's most recent quarterly MDS assessment documented she required physical assistance for personal hygiene and toileting. Resident #9 was assessed to be cognitively intact. Resident #9's 10/2/09 "Self Care Deficit" plan included in the "Approach" section the resident required extensive assist with ADLs. Resident #9's Monthly Flow Report for Daily Care (MFR) included an area to document the resident's teeth were brushed on the day and evening shift. The March MFR did not document the resident's teeth had been brushed 8 times on	F 312	**Corrective Action for Specific Residents and other Residents** Resident's #7 and #9 have teeth brushed 2x per day or per resident preference and is documented. **Other Residents Affected** Other residents may be affected and will have their teeth brushed x2 per day or per resident preference. **What measures will be put into place/systemic changes to prevent recurrence** In-service C.N.A.'s ensuring mouth care/teeth brushing is done 2x day or per resident preference and documented. **Monitoring to ensure deficiency does not recur** Audit: Nurse managers to do audits for documentation of oral care on MFR. • 3x/week q8 weeks • 1x month q2 months Audit: Nurse Manager to observe 5 random residents/ week for completion of oral care • 1x week q8 weeks • 1x monthly q2 months	Audits to begin 5/17/13 Audits to begin 5/17/13

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	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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F 312	Continued From page 30 the day and 8 times on the evening shift (16 times). On 4/11/13 at 1:45 p.m. Resident #9 stated she was assisted to brush her teeth 2-3 times a week at bedtime. When asked if she was assisted to brush her teeth every night the resident stated it would be a "lie" to say her teeth were brushed every night. On 4/11/12 at 9:20 a.m. the DON was asked how often Resident #9 was to be assisted to brush her teeth. The DON responded teeth were to be brushed 2 times a day. When asked if there was any where else the documentation would be the DON stated it was "unknown" if the resident's teeth had been brushed on the days the MFR was not documented. 2. Resident #7 was admitted to the facility on 10/19/09 with diagnoses which included CVA (cerebrovascular accident), hypertension, UTI (urinary infection) and sepsis. Resident #7's 2/11/13 MDS assessment documented moderate cognitive impairment and the resident required limited assistance for personal hygiene. The resident's 10/29/09 CP for Self Care Deficit included in the Approach section he was to have dental consults as indicated and to "Ensure that teeth are brushed in am and at HS (hour of sleep)." Resident #7's 3/13 MFR for Daily Care did not document the resident's teeth were brushed 4 times on day shift and 2 times on evening shift. The 4/1/13 -4/10/13 MFR did not document the resident's teeth were brushed on the day shift on 4/8/13 and on 4/9/13 in the evening.	F 312	Residents will be interviewed at Resident Council if oral care is being completed beginning in May • 1x month q4 months ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013** F315	Audits to begin 5/17/13

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	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 31 On 4/11/13 at approximately 1:00 p.m. Resident #7 stated he was not assisted to brush his teeth on a daily basis. The resident replied a CNA on day shift helped him brush his teeth about once a month and no one on evening shift assisted him to brush his teeth. The Administrator, DON, Nurse Consultant, AIT, and ADON were informed of the above concern. On 4/12/13 the facility provided additional documentation for "Mouth Care" for resident #7. The information was included in the example as days teeth were brushed.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the facility's Policy & Procedures, it was determined the facility failed to complete a thorough urinary assessment and implement an appropriate individualized toileting program for 1 of 11 (#9) sampled residents. This failed practice created the potential for unnecessary bladder incontinence. Findings include:	F 315		

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	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 32 The facility's Bowel and Bladder Policy and Procedure, revised 03/11, documented the following under Guidelines to Assessment: *During the admission process, the nurse will complete the urinary status interview form with input from the resident and/or family in order to obtain the history and treatment of the resident prior to admission to the facility. *...The Urinary Incontinence Assessment will be completed no later than 7 days after admission in order to obtain a good understanding of the resident's bladder patterns. *The charge nurse will complete the assessment for bladder training if the resident is incontinent to determine if the resident is a candidate for individual training or timed/scheduled toileting. *A quarterly assessment for bladder is completed if the resident is incontinent. If there has been a change from last quarter to this quarter, and the score is 0-14, proceed to completing the Urinary Incontinence Assessment. The risk factors should trigger the referrals that need to be made and should be care planned. *The interdisciplinary team will identify in the care plan specific interventions that minimize potential adverse effect of urinary incontinence...The resident will be placed in a bladder program appropriate for the resident. *Document in the nurses' notes the program initially chosen to follow in the protocol daily for at least 7 days, evaluating the program and adjusting it every few days until a pattern has been established. The program should then be evaluated weekly for 2 weeks to progress or lack of progress, then monthly on the monthly summary. Resident #5 was admitted to the facility on	F 315	**Corrective Action for Specific Residents and other Residents** Resident #5 has an individualized toileting program that is care planned. **Other Residents Affected** Other residents have the potential to be affected and will be assessed for an individualized toileting program if indicated by a score of 7-14 on urinary incontinence assessment and appropriate and desired by resident. **What measures will be put into place/systemic changes to prevent reoccurrence** In-service: Licensed staff, nurse managers, MDS nurse, restorative nurse have been in serviced to accurately assess and develop an individualized toileting program for residents if they score between 7-14 on the urinary incontinence assessment if appropriate and desired by resident to promote continence. Also in-serviced that toileting programs must be care planned. C.N.A.'s have been in-serviced on following individualized toileting plans.	

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	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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F 315	Continued From page 33 11/01/11 with multiple diagnoses including: heart failure, GERD, pneumonia, depression, anxiety disorder, and COPD. Resident #5's significant change MDS, dated 10/30/12, documented: * She had the ability to express her ideas, and wants verbally, and she had the ability to understand others. * She required extensive assist by one person for transfers and toileting. *She had a trial toileting program (scheduled toileting; prompted voiding, or bladder training) on admission or reentry to the facility. *She was frequently incontinent and on a current toileting program or trial. Resident #5's Care Plan, dated 10/30/12, failed to include a care plan for incontinence. A facility document "Urinary Incontinence Assessment" was not completed. A facility document "Assessment for Bowel and Bladder Training" dated 11/6/12 was incomplete, but contained the following documentation: *On page (1), her total assessment score was "12" and the assessment scale key documented 7-14=Candidate for toileting, timed, or scheduled voiding. *On page (2), the assessment scale key documented. If the score is 0-14: on quarterly review, if score is changed from last quarter, complete "Urinary Incontinence Assessment." The facility documented, "proceeding to urinary incontinence assessment." The facility failed to provide documentation that the assessment was completed.	F 315	**Monitoring to ensure deficiency does not recur** Audit: Nurse managers to audit urinary incontinence assessment (UIA) within 7 days of admission. Nurse manager to audit that individualized toileting plans are implemented and care planned for new residents, if indicated by score of 7-14 on UIA if appropriate and desired by resident. MDS nurse to audit per MDS schedule that current residents have individualized toileting plans that are care planned if the UIA score is 7-14 if appropriate and desired by resident. • 1x weekly q8 • 1x monthly q2 ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13

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F 315	Continued From page 34 Resident #5's electronic documentation for March 2013 and April 2013 had multiple days on various shifts without documentation for toileting or "the activity did not occur." Examples include: *Day Shift no documentation for 3/9, 3/10, 3/14, 3/25, 3/28, 3/30, and 4/6/2013. *Night Shift no documentation for 3/7, 3/9, 3/10, 3/11, 3/12, 3/16, 3/19, 3/22, 3/23, 4/1, 4/2, 4/3, 4/4, and 4/5/2013. *Evening Shift, "activity (toileting) did not occur" 3/1, 3/5, 3/8/2013. *Night Shift, "activity (toileting) did not occur" 3/2/2013. The DON and RN Consultant were interviewed on 4/11/13 at 10:00 a.m. and indicated, "it is a facility practice and a standardized program for residents to be toileted every 2 hours. This standardized program is not specific to a resident's individualized toileting program." On 4/11/13 at 3:30 p.m. the Administrator was notified. No additional information was provided.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate	F 322		

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F 322	Continued From page 35 treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of policies and procedures (P&P) regarding tube feedings, it was determined the facility failed to ensure residents who received tube feedings, received the appropriate treatment and services. This affected 1 of 2 residents (#10) reviewed for feeding tubes. Resident #10's feeding tube was not flushed with water prior to starting a feeding, as ordered. This failure created the potential for the resident to receive inadequate fluid hydration and could place the resident at risk for dehydration. Findings included: Resident #10 was admitted to the facility on 1/30/13 with multiple diagnoses which included quadriplegia, tracheostomy, and dysphagia (difficulty swallowing). The resident's admission MDS assessment, dated 2/6/13, coded, in part: * Moderate cognitive impairment with a BIMS score of 10; * Total 2 person assistance for bed mobility, transfers, dressing, toilet use, and bathing; * Total 1 person assistance for eating;	F 322	**Corrective Action for Specific Residents and other Residents** Resident #2 feeding tube is flushed with water prior to starting feeding. **Other Residents Affected** Other residents with feeding tubes could be affected and will have their feeding tubes flushed with water prior to starting feeding, unless otherwise directed by physician orders. **What measures will be put into place/systemic changes to prevent recurrence** In-service: nurses to flush tube with water prior to starting feeding, unless otherwise directed by physician orders. **Monitoring to ensure deficiency does not recur** Audit to ensure tube feeding flushes prior to feeding is occurring, unless otherwise directed by physician orders. Nurse managers to audit: • 1x week q8 weeks • 1x month q2 months ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13

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F 322	Continued From page 36 * Functional limitations in range of motion in both upper and lower extremities; * Tube feeding (TF), 51% or more nutrition and 501.cc (cubic centimeter) or more fluids per TF. Resident #10's Care Plan identified the problem, "Resident has a need for use of a feeding tube Relating to Dysphagia" on 1/30/13. One of the interventions was, "Administer tube feeding formula and flushes as ordered (see current physician orders/MAR)." Resident #10's recapitulation of Physician Orders for April 2013 included the following: * "Flush with 30-50 cc H2O [water] prior to and after meds [medications] and feedings Every Shift." The order was dated 1/30/13. * "Promote with Fiber @ [at] 120 cc/hour [times] 16 hours." This order was dated 2/20/13. Note: The "Type" of both orders was documented as "TF." On 4/8/13 at 3:10 p.m., LN #2 was observed as she aspirated Resident #10's PEG (percutaneous endoscopic gastrostomy) tube to check for residual stomach contents. Approximately 10 milliliters (mls) of residual fluid was aspirated, which the LN promptly returned to the resident's stomach. Then, LN #2 started the feeding of Promote with Fiber at 120 ml/hour via the resident's PEG tube and through a feeding pump. The resident's April 2013 MAR included the aforementioned orders for the TF water flush before and after meds/meals and Promote with Fiber. Regarding the water flush order, staff initials were documented in the spaces for the Noc (Night), Day, and Evening shifts, on 4/1	F 322		

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F 322	Continued From page 37 through 4/8/13, and Noc and Day shifts on 4/9/13. Regarding the Promote with Fiber order, staff initials were documented in the spaces noted as, "3:00 pm on" and "7:00 am off," on 4/1 through 4/8/13, and at "7:00 am off" on 4/9/13. At 3:15 p.m., upon return to the Nurses' Station, LN #2 initialed Resident #10's April 2013 MAR in the space for 30-50 ml of water prior to and after meds/meals. When asked about the water flush, LN #2 confirmed she had not administered 30-50 ml of water before she started the Resident #10's tube feeding. About that time, the First Floor Unit Manager (FFUM) joined the conversation and indicated the aspirated residual fluid would have served as the water flush. However, after review of the physician's order for 30-50 ml water flush before meds/meals, LN #2 again acknowledged that she had not administered the water flush "this time." On 4/11/13 at 3:30 p.m., the Administrator and DON were informed of the issue. However, no other information or documentation was received from the facility.	F 322		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and	F 328		

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F 328	Continued From page 38 Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure BiPAP (bi-level Positive Airway Pressure) was provided during nap time as ordered, physician orders included the settings for BiPAP, and the care plan was revised to reflect the residents' current orders for BiPAP. This was true for 1 of 2 residents (#1) reviewed for BiPAP use. These failures created the potential for the resident's condition to worsen when his respiratory care orders were not followed, complete, and care planned. Findings included: Resident #1 was admitted to the facility on 10/8/12, and readmitted on 1/19/13, with multiple diagnoses including systolic heart failure, diabetes mellitus, and debility and weakness. On 2/19/13, hospice services were started for congestive heart failure. Resident #1's significant change MDS assessment, dated 2/21/13 coded, in part: * Cognitively intact with a BIMS score of 14; * Able to hear, see, and speak without problem; * Able to understand others and to be understood; * Limited one person assistance for bed mobility and dressing; * Extensive two person assistance for transfers; * BiPAP use. A recapitulation (recap) of the resident's Physician Orders for April 2013 included the	F 328	**Corrective Action for Specific Residents and other Residents** Resident #1 bipap was dc'd due to resident refusal. **Other Residents Affected** Other residents with bipaps could be affected and will have bipap administered per physician order that includes settings. **What measures will be put into place/systemic changes to prevent recurrence** In-service nursing staff on following physician orders as indicated for bipap use and that physician orders include settings. **Monitoring to ensure deficiency does not recur** Nurse managers to audit that bipap is used per physician order • 1x week q8 weeks • 1x month q2 months Audits to begin 5/17/13 Nurse managers to audit upon admission to ensure settings on bipap are correct. • 1x week q8 weeks • 1x month q2 months Audits to begin 5/17/13 ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	

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F 328	Continued From page 39	F 328		

order, "BiPAP with at home settings at noc [night] and during nap time daily. Chart hours on." The order was dated 1/19/13. Note: No orders with "at home settings" for BiPAP were found in the resident's clinical record.

The resident's Respiratory Care Plan, dated 11/19/12, included the approach, "BiPAP as ordered at noc on home settings." Note: The care plan did not include BiPAP use during naps.

Resident #1's TAR for April 2013 included the aforementioned BiPAP order with numbered spaces (1 through 31, which represented the days of the month) for staff to document their initials and the hours the BiPAP was used at night. Note: No entries to document BiPAP use during nap time were not found anywhere on the TAR.

Resident #1 was observed napping during the day and without BiPAP in place on 4/8/13 at 3:00 p.m., 4/9/13 at 11:40 a.m. and 2:15 p.m., and 4/11/13 at 1:40 p.m.

On 4/9/13 at 3:45 p.m., CNA #5 was observed while in the process of transferring Resident #1 from his bed to his wheelchair. After that, the CNA assisted the resident into the restroom. While waiting for the resident, CNA #5 was asked if the resident used the BiPAP. The CNA stated, "He does at night." Also, when asked if BiPAP had been in place before she got the resident up that day at 3:45 p.m., CNA #5 shook her head no.

On 4/10/13 at 11:10 a.m., the First Floor Unit Manager (FFUM) was asked what were the settings on Resident #1's BiPAP. The FFUM

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F 328	Continued From page 40 reviewed the resident's clinical record, which included physician orders, then stated, "I don't know." The FFUM stated she would find out what the settings should be but she knew the settings could not be changed. Later that afternoon, the FFUM stated, "The BiPAP settings are 15/5." And, she indicated a physician's order with the settings had been written. On 4/11/13 at 1:45 p.m., when asked about Resident #1's BiPAP, LN #14 reviewed the resident's clinical record and said, "It's ordered at night." At the surveyor's request, the LN re-reviewed the BiPAP order and stated, "And during nap." At approximately 1:55 p.m., LN #14 accompanied the surveyor to resident #1's room. The resident was asleep on his right side without the BiPAP in place. LN #14 awakened the resident and asked him if he wanted the BiPAP. The resident held up his left hand and said, "Check my finger." The LN informed the resident she would get the pulse oximeter then she left the room. At approximately 2:00 p.m., LN #14 returned to Resident #1's room with a pulse oximeter and checked the resident's oxygen saturation level (SaO2). When the LN informed the resident his SaO2 was 94%, he declined the BiPAP. Immediately upon return to the nurses' station, LN #14 stated the resident "frequently refuses" the BiPAP. When asked how often the resident refused, the LN indicated she did not know and stated, "Honestly, this is the first time I've worked	F 328		

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F 328	Continued From page 41 down here in about a month." On 4/11/13 at 2:15 p.m., the FFUM was again interviewed about Resident #1's BiPAP. The FFUM stated, "I thought I care planned it for as tolerated." The FFUM then reviewed the resident's clinical record and acknowledged the BiPAP was ordered at night and during nap time, the care plan did not include "during nap time," and BiPAP use during nap time was not documented as done or monitored on the April 2013 TAR. She stated the BiPAP issues would be corrected "immediately." On 4/11/13 at 3:30 p.m., the Administrator, AIT, DON, and Nurse Consultant were informed of the BiPAP issues. However, no other information or documentation was received from the facility.	F 328		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368		

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F 368	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on group interview and staff interview, it was determined the facility failed to offer a bedtime snack to residents. This affected 6 of 7 who attended the meeting with the surveyors and had the potential to affect others who may want a bed time snack. Lack of a bedtime snack may result in the altered nutritional status of residents. Findings included: On 4/9/13 at 10:45 a.m., a group resident interview was conducted. When asked if they were offered snacks at bedtime, 6 of 7 residents in attendance stated they were not. One resident stated the snacks were available and if a resident requested one the facility would get it for them. On 4/11/13 at approximately 2:45 p.m. CNA #9 stated snacks were offered around 8:00 or 9:00 p.m. to those residents with weight loss or to diabetics after their blood glucose level was "done." On 4/11/13 at 3:00 p.m. CNA #10 stated the nurse and the resident determined who received a snack at bedtime. On 4/11/13 at 3:30 p.m. the Administrator, DON, AIT, ADON and the nurse consultant were informed of the above concern. No further information was provided by the facility.	F 368	**Corrective Action for Specific Residents and other Residents** All residents could be affected and will be offered an HS snack daily. **Other Residents Affected** All residents could be affected and will be offered an HS snack daily. **What measures will be put into place/systemic changes to prevent recurrence** In-service nursing and dietary staff to offer HS snacks to residents daily and staff will document if they accept or refuse **Monitoring to ensure deficiency does not recur** Dietary Manager to interview 10 random residents if they are being offered snacks at bedtime. • 1x week q8 weeks • 1x month q2months Residents will be asked during resident council if they are being offered HS Snacks • 1x month q3 months ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13 Audits to begin 5/17/13
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 43 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure medications were properly stored;	F 431	**Corrective Action for Specific Residents and other Residents** Resident #10: eye drops are not left at beside Resident #1: Label on medication card was corrected by pharmacy **Other Residents Affected** Other residents with eye drops, receive medications from pharmacy, or who receive influenza vaccine could be affected. Eye drops will not be left at bedside unless ordered by physician. Labels will be checked for accuracy. Influenza multi dose vials will be discarded after 28 days. **What measures will be put into place/systemic changes to prevent recurrence** In-service: LN staff to ensure eye drops are not left at bedside unless ordered by a physician, to ensure accuracy of pharmacy labels and to discard influenza vaccine by day 28.	

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	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

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F 431	Continued From page 44 medication pharmacy labels contained accurate diagnosis information and noted the frequency of the medication; and, opened flu vaccines were discarded after 28 days. This was true for 2 of 11 sample residents (#s 1 and 10) and any residents who needed, or received, a flu vaccine from a vial that was available more than 28 days after it was first used. This created the potential for incorrect administration of medications, and contamination, by unauthorized staff, visitors, or other residents, which could result in eye injury and/or infection; excessive or inadequate medication administration which could negitively affect a resident's health status; and, infection for any residents who received a potentially contaminated flu vaccine. Findings included: 1. Resident #10 was admitted to the facility on 1/30/13 with multiple diagnoses which included quadriplegia, tracheostomy, and dysphagia (difficulty swallowing). The resident's admission MDS assessment, dated 2/6/13, coded, in part: * Moderate cognitive impairment, with a BIMS score of 10; * Total assistance for all ADLs; and * Functional limitations in range of motion in both upper and lower extremities. Resident #10's recapitulation of Physician Orders for April 2013 included the orders: * "Opthalmic [sic] ointment to both eyes in am and HS [bedtime] Dx [diagnosis] Dry eyes." * "Artificial tears gel 1 drop to both eyes three times daily Dx Dry eyes." The resident's April 2013 MAR included the	F 431	**Monitoring to ensure deficiency does not recur** Audits: Nurse managers to: Audit residents with eye drops to ensure not at bedside unless ordered by a physician • 1x Week q8 weeks • 1x month q2 months Check med fridges for flu vaccines during flu season to ensure vaccines are discarded after 28 days • 1x Week q8 weeks; • 1x month q2 months Nurse Managers to audit Pharmacy labels to ensure they match new orders: • 5x week q8 weeks ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13 Audits to begin 5/17/13 Audits to begin 5/17/13

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F 431	Continued From page 45 aforementioned eye medication (med) orders and contained documentation that both meds were administered as ordered. On 4/9/13 at 9:30 a.m., during a med pass observation, LN #14 administered 9 meds, including the 2 aforementioned eye meds, to Resident #10. However, a small blue plastic cup with a single dose vial of Refresh lubricant eye drops and a tube of Refresh PM lubricant eye ointment was noted at the resident's bedside. When asked about the eye meds in the cup, LN #14 picked up the cup and exclaimed, "That's not supposed to be there." Moments later, LN #14 stated she would discard both meds and she left the room with the cup and 2 eye meds in hand. Note: On 4/17/13, an Internet search for Refresh products by Allergan, Inc., at www.drugstore.com/refresh-liquigel-lubricant-eye-drops/qxp and www.drugstore.com/refresh-sensitive-preservative-free-pm-lubricant-eye-ointment/qxp, was conducted. The search revealed the following warnings: * Refresh lubricant eye drops - "For external use only. To avoid contamination, do not touch tip of container to any surface...Do not touch unit-dose tip to eye...If swallowed, get medical help or contact a Poison Control Center right away." * Refresh PM lubricant eye ointment - "For external use only. To avoid contamination, do not touch tip of container to any surface. Replace cap after using...If swallowed, get medical help or contact a Poison Control Center right away." On 4/11/13 at 3:30 p.m., the Administrator, AIT, DON, and Nurse Consultant were informed of the	F 431		

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F 431	Continued From page 46 unattended eye meds found at Resident #10's bedside. However, no other information or documentation was received from the facility. 2. Resident #1 was admitted to the facility on 10/8/12, and readmitted on 1/19/13, with multiple diagnoses including systolic heart failure, diabetes mellitus, and debility and weakness. On 2/19/13, hospice services were started for congestive heart failure. Resident #1's significant change MDS assessment, dated 2/21/13 coded, in part: * Cognitively intact with a BIMS score of 14. The resident's recapitulation (recap) of Physician Orders for April 2013 included orders for: * Carvedilol 12.5 milligrams (mg), 1 tablet twice daily; and * Digoxin 125 microgram (mcg), 1 tablet by mouth daily. Note: A diagnosis of these medications was not listed on the recap orders. On 4/11/13 at 8:10 a.m., during a medication pass observation, LN #13 administered 8 oral medications to Resident #1. The medications included carvedilol and digoxin. The pharmacy label on the bubble pack for the digoxin, however, did not include the frequency for the medication. And, the pharmacy label for the digoxin and carvedilol noted "for hypertension" on both bubble packs. At about 8:30 a.m., Resident #1's aforementioned medications were reconciled with the physician's orders. Note: As noted above, the digoxin was ordered daily and a diagnosis was not listed for	F 431		

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F 431	Continued From page 47 digoxin and carvedilol on the April 2013 recap orders. At 9:00 a.m., when asked to rereview Resident #1's digoxin pharmacy label, LN #13 acknowledged the frequency of the medication was not listed. Also, when asked about the diagnosis "for hypertension" on the pharmacy label for the digoxin and carvedilol, the LN indicated both medications were sometimes used for hypertension. The LN was then asked to provide documentation by the physician regarding the diagnosis for digoxin and carvedilol. At 9:10 a.m., the First Floor Unit Manager (FFUM) confirmed the pharmacy label on Resident #1's bubble pack of digoxin did not include the frequency of the medication. The FFUM also provided the resident's signed Physician's Admit orders, dated 1/19/13, which included orders for digoxin and Coreg (a brand name for carvedilol). Heart failure was listed as the diagnosis for both medications. On 4/11/13 at 3:30 p.m., the Administrator, AIT, DON, and Nurse Consultant were informed of the pharmacy labeling issue. On 4/11/13 at approximately 3:45 p.m., the FFUM informed the surveyor the pharmacy had provided a new bubble pack of digoxin with the frequency and correct diagnosis and a new bubble pack of carvedilol with the correct diagnosis. 3. On 4/11/13 at 8:30 a.m., during an inspection of the First Floor Medication Room refrigerator with LN #13 in attendance, 2 opened and partially used multi-dose vials of FluLaval vaccine were	F 431		

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F 431	Continued From page 48 found. One of the vials was dated as opened 1/10/13. However, the other vial did not have an open date, which LN #13 confirmed. The LN stated that both vials would be discarded. About that time, the DON arrived, took over for LN #13, and confirmed the opened flu vaccine vials would be discarded. At 12:00 p.m., the DON was asked to provide the facility's policy regarding opened vaccines. At 1:15 p.m., the DON stated the facility did not have a policy regarding opened vaccine. She stated they use the insert information that comes with vaccines. At that time, the DON provided the FluLaval (Influenza Virus Vaccine) 2012-2013 Formula insert information which included the following, "Once entered [the seal was punctured], a multi-dose vial, and any residual contents, should be discarded after 28 days." On 4/11/13 at 3:30 p.m., the Administrator, AIT, and Nurse Consultant were also informed of the issue. However, no other information or documentation was received from the facility.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL; PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	Continued From page 49 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff adhered to standard infection control measures. This was true for 2 of 15 sample residents (#s 1 and 10). This applied when staff member did not perform hand hygiene after direct contact, including toileting assistance, for Resident #1 and Resident #10's urinary drainage bag was in direct contact the floor and above bladder level. These	F 441	**Corrective Action for Specific Residents and other Residents** Resident #10 Catheter bag will not be on floor and not above bladder. Resident #1 is having cares provided with current standards of infection control practices related to C.N.A. removing gloves and washing hands. **Other Residents Affected** Other residents could be affected who have catheters or received toileting assistance. Catheter bag will not be placed on the floor or above the bladder. Cares provided will comply with current standards of infection control practices related to C.N.A.'s removing gloves and washing hands. **What measures will be put into place/systemic changes to prevent recurrence** In-service: nursing staff on removing gloves and washing hands, catheter bags not being on floor or above the bladder	

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F 441	Continued From page 50 failures created the potential for cross-contamination which could lead to transmission of disease causing pathogens. Findings included: 1. Resident #10 was admitted to the facility on 12/18/12, and readmitted on 1/30/13, with multiple diagnoses which included quadriplegia. The resident's admission MDS assessment, dated 2/6/13, coded, in part: * Indwelling urinary catheter. Resident #10's CAA for Indwelling Catheter, dated 1/30/13, documented, "Resident has a FC [Foley catheter, a brand of indwelling urinary catheters]..." Resident #10's recapitulation of Physician Orders for April 2013 included a 2/22/13 order to change the FC each month. On 4/8/13 at 1:45 p.m., Resident #10 was observed in the resident's room in a wheelchair (w/c). The resident's urinary drainage bag was in a privacy cover suspended under the w/c. The resident's spouse was in the room. CNA #1 and another CNA transferred the resident from the w/c to bed using a Hoyer lift (a brand of mechanical lifts). During the transfer, CNA #1 took the resident's urinary drainage bag out of the privacy bag under the w/c and placed the drainage bag on the floor in front of the w/c. Note: The CNA did not use any type of barrier between the drainage bag and the floor. Less than a minute later, as the resident was lifted out of the w/c, CNA #1 lifted the urinary drainage bag off the floor and suspended it from the right front hook	F 441	**Monitoring to ensure deficiency does not recur** Audit: SDC or designee will audit by direct observation of appropriate hand washing and changing of gloves while nursing assistants are providing cares to residents. • 3x week q8 weeks • 1x week q1 month. Audits to begin 5/17/13 Audit: SDC or designee will audit catheters to ensure they are not found on floor and catheter bags are not above the bladder: • 2x/week q8 weeks • 1x month q2 months Audits to begin 5/17/13 ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	

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F 441	Continued From page 51 (as one would stand in front of and facing the resident) on the lift arm of the Hoyer. At that point, the drainage bag tubing was pulled taut and the bag itself was at least 2 feet above the resident's bladder. The family member pointed to the taut tubing and CNA #1 quickly removed the drainage bag from the hook. At that point, CNA #1 placed the urinary drainage bag on the resident's lap where it stayed until the transfer was completed and the resident was on the bed. After that, CNA #1 placed the urinary drainage bag into a privacy bag suspended from a rail on the bed frame. On 4/9/13 at 8:50 a.m., CNA #3 was observed in the process of providing incontinence care for Resident #10. The resident's uncovered urinary drainage bag was noted on the mattress near the foot of the bed. About 2 minutes later, the First Floor Unit Manager (FFUM) entered the room and assisted the CNA. In the process of moving the resident up in bed, the urinary drainage bag fell to the floor next to the CNA. However, the CNA did not pick up the drainage bag. The 2 staff continued to provide care to the resident and about 1 minute later, the FFUM asked the CNA, "What fell?" Also, the FFUM walked around the bed and said "Oh!" when she saw the drainage bag on the floor. At that point, the CNA picked up the drainage bag and placed it back on the mattress near the foot of the bed. Then, when the cares were completed, the FFUM instructed the CNA to sanitize the urinary drainage bag and the mattress. At 9:05 a.m., CNA #3 confirmed she had sanitized Resident #10's urinary drainage bag after it was on the floor, then on the resident's	F 441		

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F 441	Continued From page 52 mattress, without a barrier. On 4/11/13 at 3:30 p.m., the Administrator, AIT, DON, and Nurse Consultant were informed of the infection control issues. However, no other information or documentation was received from the facility. 2. Resident #1 was admitted to the facility on 10/8/12, and was readmitted on 1/19/13, with multiple diagnoses including systolic heart failure, diabetes mellitus, and debility and weakness. On 2/19/13, hospice services were started for congestive heart failure. Resident #1's significant change MDS assessment, dated 2/21/13 coded, in part: * Cognitively intact with a BIMS score of 14; * Extensive two person assistance for transfers and toileting. Resident #1's Care Plan included the following problems and approaches to those problems: * Potential for injury from falls related to generalized weakness and history of falls - "One assist with transfers." * Self care deficit related to generalized weakness - "Set up and cue for...toileting. Allow adequate time to complete and assist only as necessary to complete." On 4/9/13 at 3:45 p.m., CNA #5 was observed transferring Resident #1 from bed to a wheelchair (w/c) using a gait belt. The CNA then wheeled the resident into the restroom where she assisted the resident to stand up out of the w/c, pulled down the resident's pants and incontinence brief, then assisted the resident onto the toilet. The CNA	F 441		

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F 441	Continued From page 53 removed her gloves, however, she did not perform any hand hygiene. Then, while she waited for the resident, the CNA straightened the resident's bed and the area near the bed. At 3:58 p.m., CNA #5 checked on the resident. The resident asked for more time and stated, "I'm doing a BM [bowel movement]." The CNA confirmed the call light was accessible to the resident, then she left the resident's room and went directly into another resident's room, adjacent to Resident #1's room. Note: The CNA did not perform any type of hand hygiene before she left Resident #1's room and entered another resident's room. At approximately 4:02 p.m., Resident #1 activated the restroom call light and within a minute, the receptionist responded. A few moments later, CNA #5 arrived and the receptionist left. Upon entry into the resident's room, the CNA was rubbing her hands together and indicated she had used hand sanitizer. The CNA put on gloves and assisted the resident to stand. Then the CNA cleansed BM off the resident's rectal area before she cleansed the resident's scrotum, which could have transferred BM to the scrotum. On 4/11/13 at 3:30 p.m., the Administrator, AIT, DON, and Nurse Consultant were informed of the infection control issue. No other information or documentation was received from the facility.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 54 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and documentation review it was determined the facility failed to ensure the information in the medical records was accurate and complete. This had the potential to affect 4 of 15 (#s 1, 2, 4 and 5) sampled residents. Failing to have accurate documentation could create a potential for harm when residents are reviewed and the clinical picture of the resident was not accurate. Findings include: 1. Resident #2 was admitted to the facility, on 7/9/07, with diagnoses of late effect cerebrovascular dysphasia, diabetes mellitus type II, dementia with behavior disturbance, psychosis and depressive disorder. The most recent quarterly MDS, dated 12/4/12, documented the resident: * had short term memory problems, * had severely impaired decision making skills, * required extensive assistance of one to two staff for transfers, dressing, toilet use, personal hygiene and bathing.	F 514	**Corrective Action for Specific Residents and other Residents** Resident #2 and #4 will have RITA documentation completed for meals and fluid intake. Resident #1 daily weights have been dc'd and RITA documentation will be completed for meals and snacks. Resident #5 RITA documentation will be completed for toileting, diet and fluid intake. **Other Residents Affected** Other residents could be affected and will have RITA documentation completed on meals, fluid intake, toileting and snacks. **What measures will be put into place/systemic changes to prevent recurreuce** In-service: nursing staff to ensure RITA documentation is complete before leaving shift. LN to ensure C.N.A.'s complete their RITA charting before leaving shift. In-service nursing staff to ensure documentation of daily weights.	

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F 514	Continued From page 55 * was always incontinent of urine. The facility's electronic documentation was reviewed for March 2013 and April 2013. There were multiple areas that did not have documentation. Some examples include: Diet: Breakfast no documentation for 3/1, 4, 9, 10, 17, 19, 24, and 4/8/2013. Lunch no documentation for 3/1, 4, 9, 10, 13, 17, 18, 24, 25, 26 and 4/1, 4, 7, and 8/2013. Dinner no documentation for 3/3, 10, 13, 17, 20, 23, 24, 27, 31 and 4/3, 5, 7, 8/2013. Fluid intake: Days no documentation for 3/1, 4, 9, 10, 12, 13, 17, 18, 24, 25, 26/2013. Evening no documentation for 3/3, 6, 10, 11, 12, 13, 17, 20, 23, 24, 27, 30, 31/2013. The DON and consultant were interviewed on 4/11/13 at 10:00 a.m. and indicated there should not be open areas in the electronic charting. 2. Resident #4 was admitted to the facility on 10/12/12 with diagnoses of intracranial hemorrhage, altered mental status, dementia and depressive disorder. The most recent quarterly MDS, dated 1/15/13, documented the resident: * had short and long term memory problems, * was severely impaired in decision making skills, * required extensive assistance of one to two staff for transfers, dressing, toileting, personal hygiene and bathing. The facility failed to ensure the RITA documentation was complete. Some examples	F 514	**Monitoring to ensure deficiency does not recur** Audit: Nurse managers to ensure RITA documentation is complete for meals, fluid intake, snacks and toileting. Nurse Managers to ensure daily weights documented. • 3x/week q8 weeks • 1x week q2months ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	Audits to begin 5/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. BUILDING _____ B. WING _____	C 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF VALLEY VIEW	1130 NORTH ALLUMBAUGH STREET BOISE, ID. 83704

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F 514	Continued From page 56	F 514		

include:
Diet:
Breakfast no documentation for 3/1, 8, 10, 16, 17, 23, 24 and 4/7/2013.
Lunch no documentation for 3/1, 8, 10, 11, 12, 13, 16, 17, 18, 21, 22, 23, 24, 27 and 4/7/2013.
Dinner no documentation for 3/15, 21, 23, 24, 29 and 4/4/2013.
Fluid intake:
Days no documentation for 3/1, 8, 10, 11, 16, 17, 18, 22, 23, 24, and 27/2013.
Evening no documentation for 3/3, 6, 13, 18, 19, 21, 23, 24, 27, 29, and 31/2013.

The DON and consultant were interviewed on 4/11/13 at 10:00 a.m. and indicated there should not be open areas in the electronic charting.

3. Resident #1 was admitted to the facility on 10/8/12, and was readmitted on 1/19/13, with multiple diagnoses including systolic heart failure, diabetes mellitus, and debility and weakness. On 2/19/13, hospice services were started for congestive heart failure.

Resident #1's significant change MDS assessment, dated 2/21/13 coded, in part:
* Cognitively intact with a BIMS score of 14.

The resident's April 2013 recapitulation of Physician Orders included the order, "Weight resident at same time, on same scale, with similar [sic] clothes and record Daily." The order was dated 1/19/13.

The resident's Care Plan included the problem,

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F 514	Continued From page 57 "Alteration in nutrition..." One approach, "Weigh monthly" was added 2/26/13. Per interview with the First Floor Unit Manager (FFUM) on 4/10/11 at 11:40 a.m., daily weights should have been removed from the 4/13 Physician Order. She stated it was changed to monthly after the resident elected the hospice benefit. Also, the facility's electronic documentation was reviewed for March 2013 and April 2013. There were multiple areas that did not have documentation. Some examples include: Diet: Breakfast - 3/5 and 3/27/13. Lunch - 3/5, 3/10, and 3/27/13. Dinner - 3/8/13. Snacks: Am - 3/1, 3/2, 3/4 through 3/12, 3/14 through 3/16, 3/18 through 3/23, 3/25, 3/27, 3/29, 3/30, 4/1, 4/3 through 4/6, and 4/8/13. PM - 3/3, 3/16, 3/18, 3/21, 3/22, 3/26, 3/29, 4/1 4/2, 4/5, and 4/8/13. HS - 3/3, 3/16, 3/18, 3/21, 3/22, 3/26, 3/28, 4/1, 4/2, 4/5, and 4/8/13. Fluid intake: Days - 3/5 and 3/27/13. Evenings - 3/8/13. The DON and consultant were interviewed on 4/11/13 at 10:00 a.m. and indicated there should not be open areas in the electronic charting. 4. Resident #5 was admitted on 11/01/11 with multiple diagnoses including: heart failure, GERD, pneumonia, dementia, depression, anxiety disorder, and COPD.	F 514		

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F 514	Continued From page 58 The facility's electronic documentation, RITA, was reviewed for March 2013 and April 2013. Resident #5's electronic documentation had multiple days without any documentation on various shifts. Examples include: Toileting: Day Shift no documentation for 3/9, 3/10, 3/14, 3/25, 3/28, 3/30, and 4/6/2013. Night Shift no documentation for 3/7, 3/9, 3/10, 3/11, 3/12, 3/16, 3/19, 3/22, 3/23, 4/1, 4/2, 4/3, 4/4, and 4/5/2013. Diet: Breakfast no documentation for 3/1, 3/10, 3/16, 3/17, 3/22, 3/23, 3/24, 4/1, and 4/7/2013. Lunch no documentation for 3/1, 3/5, 3/8, 3/10, 3/11, 3/12, 3/13, 3/16, 3/17, 3/18, 3/22, 3/23, 3/24, 3/27, 3/31, 4/7/2013. Dinner no documenting for 3/5, 3/15, and 4/1/2013. Fluid Intake: Day Shift no documentation for 3/1, 3/8, 3/10, 3/11, 3/16, 3/17, 3/22, 3/23, 3/24, and 4/7/2013. Evening Shift no documentation for 3/3, 3/5, 3/15, 3/18, 3/27, 3/31, and 4/1/2013. The DON and consultant were interviewed on 4/11/13 at 10:00 a.m. and indicated that there should not be "holes" in the electronic charting.	F 514		

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Sherri Case, LSW,QMRP, Team Coordinator Linda Kelly, RN Arnold Rosling, RN,QMRP Amy Jensen, RN Lorraine Hutton, RN, QMRP	C 000	RECEIVED MAY 24 2013 FACILITY STANDARDS Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F164 as it related to privacy during care and treatment.	C 125	C 125 Please refer to Plan of Correction F164	
C 297	02.107,05,a Bedtime Snacks a. Bedtime snacks of nourishing quality shall be offered, and between-meal snacks should be offered. This Rule is not met as evidenced by: Please refer to F 368 as it relates to snacks being offered at bedtime.	C 297	C297 Please refer to Plan of Correction F368	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION	C 669		

Bureau of Facility Standards

Collin Seye Nuxoll — TITLE: Executive Director (X6) DATE: 5/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED.
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C 669	Continued From page 1 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it related to infection control prevention.	C 669	C669 Please refer to Plan of Correction F441	
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please refer to F 250 as it addresses the facility's failure to ensure that social services were provided as needed for a resident.	C 696	C696 Please refer to Plan of Correction F250 C720 Please refer to Plan of Correction F312	
C 720	02.153,03,a ORAL CARE AND HYGIENE 03. Oral Care and Hygiene. The facility shall ensure that patients/residents receive care in the facility which promotes a healthy mouth through: a. Regular oral care. This Rule is not met as evidenced by: Please refer to F312 as it relates to oral care.	C 720		

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C 745	Continued From page 2	C 745		
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it related to professional standards of care.	C 745	C745 Please refer to Plan of Correction F281 C782 Please refer to Plan of Correction F280	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F 280 as it relates to the revision of care plans.	C 782	C784 Please refer to Plan of Correction F322 and F309 C788 Please refer to Plan of Correction F309 and F328	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F322 as it related to appropriate care and services related to enteral nutrition via a feeding tube. Please to refer to F 309 as it relates to following the resident care plan.	C 784		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered	C 788		

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C 788	Continued From page 3 iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F 309 and F328 as it relates to resident care and the provision of services ordered by residents' physician and residents' Care Plans:	C 788	C795 Please refer to Plan of Correction F315	
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F 315 as it relates to Incontinence assessment and training.	C 795	C821 Please refer to Plan of Correction F431 C822 Please refer to Plan of Correction F431	
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F431 as it related to opened flu vaccine available for resident use after 28 days.	C 821		
C 822	02.201,01,c Medication Storage and Dangerous Chemicals c. Reviewing the facility for proper storage of medications and	C 822		

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C 822	Continued From page 4 dangerous chemicals at least every thirty (30) days and notifying the administrator of the facility of any nonconformance. This Rule is not met as evidenced by: Refer to F431 as it related to proper labeling and storage of medications.	C 822		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F 514 as it relates to maintaining complete medical records.	C 881	C881 Please refer to Plan of Correction F514	
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and	C 882		

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C 882	Continued From page 5 disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Based on closed record review and staff interview, the facility failed to ensure a cause of death was included in 1 of 1 sample residents (#18) reviewed for death in the facility. Findings included: Resident #18 was admitted to the facility on 6/19/10, and readmitted on 12/29/12, with multiple diagnoses, which included Parkinson's disease, coronary artery disease, and diabetes mellitus. The resident died in the facility on 1/1/13. Review of the resident's closed medical record revealed the final diagnosis, or cause of death, was not documented in the record. On 4/11/13 at 10:00 a.m., when asked about Resident #18's cause of death, the Medical Records Director stated, "We usually have it but the doctor didn't fill it out. I called his office and they are sending that over." On 4/11/13 at 3:30 p.m., the Administrator, AIT, DON, and Nurse Consultant were informed of the issue. No other information or documentation was received from the facility.	C 882	**Corrective Action for Specific Residents and other Residents** Resident #18: Cause of death is documented in the clinical record. **Other Residents Affected** Others residents closed medical record could be affected. Cause of death will be documented in the medical record. **What measures will be put into place/systemic changes to prevent recurrence** In-service Medical records documenting cause of death in the medical record. **Monitoring to ensure deficiency does uot recur** Audit: discharge record audits on all residents who leave facility. • 1x week q8 weeks • 1x month q2 months Audits to begin 5/17/13 ED and DNS to bring results of audit to QAPI meeting. Ongoing audits to be scheduled based on formulated trends. **Date of Compliance: 5/17/2013**	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 30, 2013

Collin "Serge" Newberry, Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

Provider #: 135098

Dear Mr. Newberry:

On **April 12, 2013**, a Complaint Investigation survey was conducted at Life Care Center of Valley View. Sherri Case, L.S.W., Q.M.R.P., Lorraine Hutton, R.N., Amy Jensen, R.N., Linda Kelly, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. The complaint was investigated in conjunction with the annual Recertification and State Licensure survey. During the survey:

- Eleven sampled residents were observed and reviewed for care and treatment; including personal hygiene and bathing, incontinence care and following physician's orders.
- Five residents and two family members were individually interviewed regarding care issues, staff treatment, nursing care and any concerns with the number of direct care staff. In addition, a resident group meeting was held and attended by seven residents. Residents attending the group meeting were asked about staffing issues, resident care issues, bathing and hygiene issues and general nursing care.
- Incident and Accident reports were reviewed for June 2012 through April 10, 2013.
- Resident Council minutes were reviewed for December 2012 through April 2013.
- The grievance file was reviewed for June 2012 through April 8, 2013.
- The identified resident's closed medical record was reviewed.
- Multiple staff were interviewed, including the Administrator, Director of Nursing, licensed nursing staff and Certified Nurse Aides(CNAs).
- Nursing schedules were reviewed and verified for July 15, 2012, through August 30,

2012, and for three-weeks prior to the survey, which included March 17, 2013, thorough April 6, 2013. The nursing schedules included licensed nursing staff as well as CNAs.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005688

ALLEGATION #1:

The complainant alleged the identified resident had C-Diff (clostridium difficile); along with open, raw, red blisters in the anal and vaginal areas. Physician's orders of August 4, 2012, were not consistently followed; e.g., keeping her brief open, legs apart, genital area open to air, fan on in room for circulation, scrupulous frequent cleansing of all urine and fecal material from her skin, etc. One week after the physician's orders, the resident's bowel movements were still loose, frequent and had a sour odor, indicating the likelihood that C-Diff was still present. The sores in the anal and vaginal areas were not significantly improving.

FINDINGS:

During review of the resident's medical record, it was verified that the resident developed perineal and parietal skin issues during her stay at the facility. The resident also developed a C-Diff infection with severe diarrhea. The resident's skin condition worsened with the diarrhea.

The resident's medical record review revealed that nursing staff failed to document that physician's orders were followed in relationship with the resident's perineal and perirectal skin condition and ordered treatments. In addition, it was determined that the resident had experienced perineal and perirectal skin issues since June 2012, but the facility did not develop an individualized care plan that addressed the resident's specific skin issues. The facility was cited for the deficient practice of not developing an individualized care plan at F280 and not following physician's orders at F309 on the Federal survey report.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant documented that multiple employees complained there were serious problems at this facility. The problems included; being dangerously understaffed due to; up to six CNAs at a time were calling in sick for any given shift, employees quitting, etc.

FINDINGS:

Nursing schedules were reviewed. Nursing hours exceeded the State of Idaho's minimum staffing requirements for skilled nursing facilities (nursing homes) for all days reviewed. There were no days found, through review of the schedules and interviews with staff that indicated a shift (or shifts), on which six staff members called in sick. The facility was able to demonstrate that staff who called in sick was generally replaced by another staff member.

Incident and accident reports for June 2012 through April 10, 2013, demonstrated no acute increase in the number of falls, skin tears or other accidents, which could indicate insufficient staffing. In addition, interviews with current residents and families revealed no concerns with care issues related to low staffing.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Loretta Todd

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 9, 2013

Collin "Serge" Newberry, Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

Provider #: 135098

Dear Mr. Newberry:

On **April 12, 2013**, a Complaint Investigation survey was conducted at Life Care Center of Valley View. Sherri Case, L.S.W., Q.M.R.P., Lorraine Hutton, R.N., Amy Jensen, R.N., Linda Kelly, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. The complaint was investigated in conjunction with the annual Recertification and State Licensure survey. During the survey:

- Sixteen sampled residents were reviewed for care and treatment. This included the eight residents identified in the complaint.
- Five residents and two family members were individually interviewed regarding care issues; staff treatment; privacy, dignity and/or respect issues and nursing care. In addition, a resident group meeting was held and attended by seven residents. Residents attending the group meeting were asked about staffing issues; resident care issues; privacy, dignity and/or respect issues, as well as general nursing care.
- Incident and Accident reports were reviewed for June 2012 through April 10, 2013.
- Resident Council minutes were reviewed for December 2012 through April 2013.
- The grievance files were reviewed for June 2012 through April 8, 2013.
- Multiple staff were interviewed, including the Administrator, Director of Nursing, Licensed Nursing staff and Certified Nurse Aides (CNA) staff.

Please note that the review and sharing of resident's information is governed by privacy regulations under HIPPA (Health Information Portability and Accountability Act). Because of these requirements, very little specific information on residents can be shared with people other than those who have a legal right to the information.

To protect each residents' privacy, the complainant's substantiated concerns will be referenced to a citation (F Tag) in the Federal Survey Report (CMS-2567) dated April 12, 2013. If a concern was not substantiated, this letter will briefly state why it was not substantiated, but no specific details on residents will be provided.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005714

ALLEGATION #1:

The complainant stated an identified resident did not receive physician's ordered hemorrhoid treatments twice per day.

In addition, the same resident received too much constipation medication, as evidenced by the resident having loose, liquid bowel movements (BMs) about three to four times a day. Sometimes the resident's clothes would have to be changed due to how liquid the BMs were. Licensed nursing staff did not respond to concerns regarding the diarrhea.

FINDINGS:

The complainant's concerns, that an identified resident did not consistently receive physician's ordered hemorrhoid care was substantiated, based on review of physician's orders, medication administration records and nurse's notes for the months of July 2012 through September 2012 as well as resident's and staff interviews. The facility was cited for not following physician's orders. Please refer to F309 on the April 12, 2013, Federal CMS-2567 report.

The concern that the same identified resident had frequent bouts of liquid stools that nursing staff did not respond to could not be substantiated, based on review of medication administration records, nurses note's and CNA documentation of toileting and incontinence care for the months of July 2012 through September 2012.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated that when residents have to have their blood glucose levels checked before breakfast, the licensed practical nurses (LPNs) do the blood glucose checks in the dining room, in front of other residents, while residents are waiting for breakfast to be served. The LPNs also give insulin injections in the dining room during the breakfast meal, in front of all residents who are dining.

The complainant identified three residents who received their glucose checks and/or insulin in public places.

FINDINGS:

Interviews with residents and family members substantiated that LPN staff did, at times, do blood glucose checks and give insulin in public areas. The facility was cited for not maintaining resident's privacy during medical treatments. Please refer to F164 on the April 12, 2013, Federal CMS-2567 report.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated that the facility's licensed nursing staff has left an identified resident's medications at the bedside when the resident eats in his/her room. When the resident eats in the dining room, the medications were left on the table where the resident sits.

The Licensed Nurses (LNs) dispense resident's medications into a medication cup and places the medications on the table where the residents are seated. The LNs tell the residents to take their medications and before watching the residents swallow the medications, they go on to another resident and do the same thing. There have been numerous occasions, when the residents spilled their medications on the floor. For example, one day, an identified staff member picked up four pills that were under the table for two female residents.

FINDINGS:

It was determined during residents' interviews, staff interviews and records review, that the resident identified as having medications left on her tray table and/or by her food in the dining room had been assessed by the interdisciplinary team to be safe and able to self-administer medications. In this situation, it would be an acceptable practice for licensed nursing staff to leave the medications by the resident's food during meal times.

Housekeeping staff were interviewed for both the upstairs and downstairs dining rooms. The housekeepers were asked if they had found medications on dining room floors when they cleaned up after meals. One of the housekeepers stated that "several" months ago she found pills lying under the table, on the floor, in the dining room on the second floor. She told the nurse about the medications. The nurse picked them up and threw the medications away. Other than on this occasion, the housekeeper stated she has not found medications on the dining room floors or on the floors in residents' rooms. The second housekeeper said that she had never found medications on the dining room floor or

in the residents' rooms.

Although the specifics of the complaint could not be substantiated, eye medications were observed lying at a resident's bedside during the survey. The resident was not able to self-administer medications, and the medication nurse who was interviewed regarding the medications indicated the eye medications should not have been left at the resident's bedside. The facility was cited for failure to store medications properly. Please refer to F431 on the April 12, 2013, Federal CMS-2567 report.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant stated that another identified resident stopped receiving her medications because licensed nursing staff could not get the resident to take medications from them. When licensed nurses were told by CNA staff that the resident might take the medications if they were put in yogurt, some licensed nursing staff refused to try it.

FINDINGS:

It was determined through review of the resident's medical record for July 2012 through September 2012, interviews with staff and observation of meals and medication administration during the survey, that medication changes had been made on the identified resident because of her frequent refusal to take oral medications. The medications were offered to the resident in puddings, applesauce and/or yogurt, but the resident continued to refuse them. Licensed nursing staff asked for and received an order to discontinue many of the resident's medications. The medication changes made were appropriate for the identified resident, and the resident became more cognitively aware and interactive since the medications were discontinued. The resident's care plan addressed her frequent refusal of medications and food and provided a variety of interventions for staff to utilize. The resident was observed during three meals and a medication pass during the survey. Staff were successful, using the care planned interventions, in getting the resident to eat and take medications.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated that another identified resident had liquid stools that smelled like clostridium deficile (C-dif). An identified CNA approached a nurse and asked if the resident had been tested for C-dif. The nurse told the identified CNA, "...I am a nurse. You do your job, and I will do my job." The facility did not have the resident checked for C-dif when the CNA told the nurse about it. In addition,

another identified CNA told licensed nursing staff that the identified resident needed to be checked for C-dif because that CNA knew that the resident had C-dif. By this time, the resident's peri-area was blistered and bleeding, and the resident cried while receiving peri cares. A few days later, the facility had the resident checked for C-dif and it came back positive. This happened sometime around July 2012.

FINDINGS:

Review of CNA documentation of bowel movements, review of the identified resident's physicians orders, nursing notes and medication administration sheets for July 2012, as well as staff interviews revealed no consistent problems with liquid stools until after the resident received bowel care on July 18, 2012. The CNA documentation indicated the resident had not had a bowel movement for two days (July 16 and 17, 2012). When the resident was still having liquid stools on July 20, 2012, the resident's physician was notified and the resident was tested for C-dif and placed in isolation precautions. The lab verified a diagnosis of C-dif on July 23, 2012, and the resident began antibiotic treatment. No deficient practice was found.

During the investigation of a related complaint regarding the resident's skin issues, it was found that the facility did not care plan the resident's identified skin issues nor did they follow physician's orders to help resolve those issues. The facility was cited at F280 and F309. Please refer to the Federal CMS-2567 dated April 12, 2013.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 30, 2013

Collin "Serge" Newberry, Administrator
Life Care Center of Valley View
1130 North Allumbaugh Street
Boise, ID 83704

Provider #: 135098

Dear Mr. Newberry:

On **April 12, 2013**, a Complaint Investigation survey was conducted at Life Care Center of Valley View. Sherri Case, L.S.W., Q.M.R.P., Lorraine Hutton, R.N., Amy Jensen, R.N., Linda Kelly, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. The complaint was investigated in conjunction with the annual Recertification and State Licensure survey on April 5, 2013, through April 12, 2013.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005783

ALLEGATION #1:

The complainant stated the facility does not ensure residents are groomed properly.

FINDINGS:

Based on resident and staff interviews and review of documentation of grooming, the complaint was substantiated and the facility was cited at F312.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated clothing is missing and not replaced.

FINDINGS:

The surveyors met with eight residents residing at the facility. All eight residents who attended the meeting stated there was not an issue with losing clothing or personal property. One resident stated that sometimes when clothing was sent to the laundry it would be missing for a short while, but the facility would look for the item and it would be returned.

Additionally, interviews were completed regarding the facility losing resident's clothes or personal items with four individual residents and three family members. All stated there was not a problem with the facility losing clothing or personal items.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Loretta Todd

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj